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The right of everyone to the enjoyment of the highest attainable standard of physical and mental health

Note by the Secretary-General**

The Secretary-General has the honour to transmit to the members of the General Assembly the report of the Special Rapporteur of the Commission on Human Rights on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt, submitted in accordance with Commission resolution 2005/24.

* A/60/150.
** This report is submitted late in order to reflect as much updated information as possible.

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Summary

The right of everyone to the highest attainable standard of physical and mental health ("the right to health") requires access not only to timely and appropriate health care, but also to the underlying determinants of health, such as adequate sanitation, safe drinking water, food, nutrition and housing. The World Health Assembly recently established, for a three-year period, an important commission to study the social dimensions of health: the Commission on Social Determinants of Health. Section II of the present report notes the congruity between the Commission's mandate and the dimension of the right to health of the underlying determinants. The Special Rapporteur looks forward to interacting with the Commission and learning how it proposes to integrate the right to health into its work.

Health professionals have an indispensable role to play in the promotion and protection of human rights, including the right to health. Section III of the report considers the importance of health professionals' education in human rights and notes that inadequate attention is given to the right to health and other human rights in the curricula of medical and nursing schools around the world. In his country missions, the Special Rapporteur will continue to examine the degree to which health professionals receive human rights education, as well as the human rights support they are provided by States and national health professional associations.

The report's most substantive section is on the migration of health professionals, sometimes known as the "skills drain" or "brain drain". As the Special Rapporteur highlighted in his last report to the General Assembly (A/59/422), health is strikingly prominent in the Millennium Development Goals. If the international community is serious about achieving the Goals, it has to be serious about strengthening health systems, addressing the "precarious condition" of health professionals, and the skills drain. In today's world, there is a shocking inequality in levels of health care and protection. The skills drain has to be seen in the context of this alarming global health inequality.

The report sketches the scale of health professionals' migration from developing to developed countries, as well as the "push" and "pull" factors that contribute to the skills drain. Three clusters of human rights are especially relevant to the skills drain: freedom of movement; labour rights; and the right to health, which encompasses a right to an effective and inclusive health system of good quality. The report focuses on the right to health, including participation, international assistance and cooperation, and accountability. It particularly considers the right to health in relation to those countries from which health professionals migrate.

After reproducing some guiding principles, the section concludes by emphasizing that if human rights are integrated into national and international policies bearing upon the skills drain, this is likely to make the policies more effective, robust, equitable, inclusive and meaningful to those living in poverty. The conclusion briefly considers three possible policy responses to the skills drain: strengthening health systems in countries of origin; ethical recruitment by destination countries; and compensation or restitution. It suggests that developed countries establish independent national offices to monitor their international cooperation on health, including those polices relating to the skills drain.

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I. Introduction

1. The Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health ("right to health") submitted his annual report (E/CN.4/2005/51 and Add.1-4) to the Commission on Human Rights at its sixty-first session, in accordance with the mandate set out in Commission resolution 2004/27. In its resolution 2005/24, the Commission welcomed the report and again requested the Special Rapporteur to submit annually a report to the Commission and an interim report to the General Assembly on the activities performed under his mandate. The present report is submitted in accordance with Commission resolution 2005/24.

2. Since he submitted his annual report to the Commission in February 2005, the Special Rapporteur has undertaken a country mission to Uganda (15-25 March), at the invitation of the Government and with the support of the World Health Organization (WHO), to address the issue of neglected diseases and the right to health. A report on his mission will be submitted to the Commission at its sixty-second session. The Special Rapporteur also has issued a number of urgent appeals and other communications to various Governments, as well as statements and press releases on issues ranging from the rights to sexual and reproductive health to the impact of trade agreements on access to medication. He will report on these communications in his forthcoming annual report to the Commission.

3. The Special Rapporteur also has participated in meetings including the annual meeting of special procedures organized by the Office of the United Nations High Commissioner for Human Rights; various consultations with WHO, including with WHO regional directors; a meeting in Berlin, sponsored by WHO and GTZ, on intensified control of tropical diseases; and a panel discussion on neglected diseases, which was held during the World Health Assembly. In February he attended a meeting in New York, organized by the Ethical Globalization Initiative, to discuss the role of pharmaceutical companies in relation to the right to health. In April the Special Rapporteur delivered a keynote address at a conference on "Lessons learned from human rights-based approaches to health", which was organized by the Institute of Human Rights of Emory University, Atlanta, United States of America, in collaboration with WHO, CARE USA, the Carter Center human rights office, the United States Centers for Disease Control and Prevention (CDC), and Doctors for Global Health. In July, the Special Rapporteur met with developing country delegates to the World Trade Organization and others to discuss issues related to General Agreement on Trade in Services (GATS) mode 4 and the migration of health professionals. He also chaired a meeting at the Human Rights Centre, University of Essex, United Kingdom, which was sponsored by the International Federation of Health and Human Rights Organizations, to discuss future strategies and priorities for the right to health mandate.

4. For ease of reference, all the Special Rapporteur's reports to the General Assembly and the Commission on Human Rights, in addition to his press statements and a collection of his speeches and interventions on the right to health, can be found on the website of the Human Rights Centre, University of Essex, http://www2.essex.ac.uk/human_rights_centre/rth.shtm. All United Nations documents related to the work of the Special Rapporteur, including press statements and reports to the General Assembly and the Commission on Human Rights, are

available on the website of the Office of the High Commissioner for Human Rights at http://www.ohchr.org/english/issues/health/right/.

II. Commission on Social Determinants of Health

5. In accordance with international human rights law, realizing the right to health requires access not only to timely and appropriate health care, but also to the crucial "underlying determinants" of health.[1] These include factors that influence health such as safe drinking water and food, adequate sanitation and housing, healthy work and environmental conditions, and so on. From the outset, the Special Rapporteur has addressed these issues throughout his mandate, including in the course of his country missions.[2]

6. Recognizing the vital importance of the underlying determinants of health, the World Health Assembly recently established, for a three-year period, an important commission composed of leading policymakers and practitioners, in order to study the social dimensions of health. The Commission on Social Determinants of Health seeks to translate public health knowledge into actionable global and national policy agendas, in order to improve health and access to health care. Information about the Commission can be found on the WHO website at www.who.int/social_determinants/en/. In brief, the Commission's work includes compiling and analysing scientific evidence on social mechanisms that shape health and health inequities, developing policy recommendations to strengthen health and advance health equity through action on social determinants, and advocating for implementation of recommendations in countries.

7. There is considerable congruity between the Commission's mandate and the "underlying determinants of health" dimension of the right to health, as well as other interconnected human rights such as adequate housing, food and water. In other words, national and international human rights law informs and reinforces the Commission's mandate. At a preliminary informal meeting with members of the Commission secretariat, the Special Rapporteur expressed his firm support for the Commission's important and far-reaching mandate. He looks forward to further interaction and to learning how the Commission proposes to integrate the right to health into its work. If the Commission wishes, the Special Rapporteur will be pleased to provide whatever support his very limited resources permit.

III. Health professionals and human rights education

8. The practice of health professionals has a significant bearing on the promotion and protection of human rights, in particular the right to health. As providers of health-care services, health professionals play an indispensable role in the realization of the right to health. They have also often played an important role in helping document and redress violations of human rights, such as violence and torture.

9. While the vast majority of health professionals have made valuable contributions towards human rights, some have, wittingly or unwittingly, been complicit in human rights violations. Political, legal, economic, social or cultural pressures that may conflict with human rights mean that they sometimes have to

make decisions in their daily practice which have profound human rights implications. Personal views of health professionals may also influence their practice: at times, their views may be inconsistent with the rights of patients. For example, in some countries, health professionals are subjected to institutional or societal pressures, or make decisions based on their own views and conscience, to deny treatment to marginalized groups, such as immigrants; disclose confidential medical records; or deny sexual and reproductive health information to women or adolescents. Health professionals have also, at times, been subject to pressures to participate in human rights violations including torture, forced sterilizations, and female genital cutting/mutilation. Decisions made by health professionals can mean the difference between the protection or violation of human rights.

10. In his preliminary report to the Commission on Human Rights, the Special Rapporteur indicated his intention to examine the roles and responsibilities of health professionals towards the right to health, as well as to the difficulties that they face in this regard (E/CN.4/2003/58, paras. 95-98). This chapter makes some introductory remarks about just one issue concerning health professionals, namely the importance of their education in human rights.

11. Inadequate compliance by health professionals with human rights standards is often the result of complex and interrelated circumstances, including political pressures and societal influences. However, it is often partly attributable to inadequate or non-existent training in human rights.[3] Human rights education is an essential starting point for equipping health professionals with the knowledge and tools to empower them to promote and protect human rights. As well as enabling them to defend the rights of their patients, human rights education also has an important role to play in assisting health professionals defend their own human rights.

12. The value of educating health professionals in human rights has been widely endorsed by States and the health and human rights communities worldwide. In the Vienna Declaration and Programme of Action, adopted in June 1993 by the World Conference on Human Rights, States recognized the importance of special education in human rights and humanitarian law for health professionals. The World Medical Association (WMA) strongly recommends that medical schools include medical ethics and human rights as an obligatory course in their curricula.[4] The International Council of Nurses, in its position on nurses and human rights adopted in 1998, advocates inclusion of human rights issues and the nurses' role in all levels of nursing education programmes.[5] The Committee on the Elimination of Discrimination against Women recommends that Governments "[e]nsure that the training curricula of health workers includes comprehensive, mandatory, gender-sensitive courses on women's health and human rights, in particular gender-based violence".[6]

13. Recent years have witnessed the development of many excellent human rights training manuals and courses for health professionals. These range from general ones to those addressing health-related human rights in specific circumstances where human rights are most at risk, such as in prisons and reproductive health-care services, or the health-related human rights of vulnerable groups, such as refugees.[7] Recent research by the British Medical Association and WMA also shows that there is demand among medical students worldwide to learn more about human rights and ethics during their education.[8] The Special Rapporteur is greatly encouraged by

these developments. However, he is also very concerned at the inadequate attention given to the right to health and other human rights in curricula of medical and nursing schools and textbooks around the world. Many health professionals simply do not receive education in human rights.

14. While the subject of human rights is regrettably normally absent from medical and nursing education, many medical and nursing schools and textbooks do integrate teaching on bioethics. Bioethics and human rights derive from similar core values. Bioethical frameworks provide valuable, and often human rights-compatible moral guidance to health professionals relating to their professional conduct. The importance of training in bioethics cannot be overemphasized. However, human rights education is also of importance if health professionals are to be fully equipped to defend human rights as an important component of their professional practice. Human rights are grounded firmly in international legal instruments and are subject to a number of monitoring mechanisms. They have a particular preoccupation with accountability and non-discrimination, as well as the protection of the most vulnerable members of society. Human rights therefore provide health professionals with extremely useful tools for promoting and protecting the rights and well-being of patients, as well as their own human rights.

15. To some extent, what health professionals need to know will depend on the country in which they work, as well as their professional specialization. At a minimum, all health professionals should receive education on the human rights of patients, including their right to health; the health-related human rights of vulnerable groups, such as women, children and people with disabilities; and their own human rights relating to their professional practice. Human rights education should also always include practical instruction in how to implement a human rights approach in clinical practice, including how to maintain respect for the inherent dignity of all patients, resist institutional or societal pressure to commit violations, identify violations, empower patients or colleagues to defend their human rights, and promote accountability in relation to known or suspected abuses, as well as minimizing risks of reprisals. More specialized human rights education should be provided to health professionals working in those situations most likely to generate human rights violations, or bring them into contact with evidence of abuses, including in forensic medicine, prisons, mental health services, family planning services, situations of armed conflict, or working with vulnerable communities.

16. Under international human rights law, States have the primary obligation to ensure the right to the enjoyment of the highest attainable standard of health. The Special Rapporteur therefore emphasizes the central importance of States building an environment that supports the adoption of rights-based approaches by the health professional community. It is particularly important that States do not place health professionals in a position where they may be called on to use their skills to further violations of human rights of the people they serve, and that States provide accountability mechanisms to redress or prevent human rights violations in the context of clinical practice. However, other actors also have an important role to play. Medical and nursing schools and other bodies training health professionals should integrate human rights education and training at all professional levels. Building on existing examples of good practice, national health professional associations should raise awareness about human rights and stimulate demand for human rights education among their members, and they should also assist health professionals involved in defending human rights through providing specialist

advice and institutional support. Although the focus of this particular chapter is the human rights education of health professionals, the Special Rapporteur notes in passing that law schools and other human rights training institutions should include the right to health and other health-related human rights in their curricula.

17. In his country missions, the Special Rapporteur seeks — and will continue to seek — information on whether health professionals receive human rights education, and how far States and national health professional associations support health professionals to promote and protect human rights.

IV. The skills drain: the migration of health professionals

18. The migration of health professionals, in particular doctors and nurses but also midwives, pharmacists, dentists, technicians and others, raises serious right to health issues.

19. The movement of health professionals is not in one direction, but many. Overall, however, net migration occurs away from rural to urban areas, from the public to the private sector, from poorer to wealthier developing countries, from fragile to more stable States, from developing to developed countries, and from developed countries with poorer health sector terms and conditions to developed countries with better health sector terms and conditions. This phenomenon is often referred to as the "skills drain" or the "brain drain".

20. This chapter focuses on the international dimension of the skills drain, in particular the migration of health professionals from developing to developed countries.[9] The Special Rapporteur recognizes, however, the interlinked crises in many countries of rural-urban, and public-private migration that deprive poor and rural populations of much needed health care.

21. While it is well known that the skills drain raises human rights issues such as the freedom of movement and labour rights of health workers, the impact of the skills drain on the enjoyment of the right to health in developing countries of origin is frequently neglected. This aspect of the skills drain is the primary focus of this chapter.

22. In today's world, there is a shocking inequality in levels of health care and protection. The skills drain — developed countries employing health professionals trained at the expense of, and desperately needed in, developing countries — deepens this global health inequality. Policies that are intended to tackle the skills drain must address, in a systematic and coordinated manner, global health inequality.[10]

A. Increasing recognition of the skills drain as a global problem

23. The need to address the skills drain is now widely recognized. In 2004 and 2005, for example, the World Health Assembly adopted resolutions recognizing that migration and recruitment of health personnel from developing to developed countries is a major challenge for health systems in developing countries.[11] Additionally, there is now an extensive and expanding literature on the causes and consequences of the skills drain in the health sector.[12]

24. Moreover, the skills drain is beginning to generate media interest and public concern. Prior to the Group of Eight (G-8) Summit in Gleneagles, Scotland, in July 2005, for example, London's *Financial Times* carried a large advertisement under the banner headline "How Long Will the Poorest Countries Train Health Workers for the Richest?".[13] At the Summit, leaders committed to invest in improved health systems in partnership with African Governments, including by helping Africa to train and retain health professionals.[14] Such commitments must be actioned, extended and monitored — an issue that is revisited in the conclusion to this chapter.

B. The Millennium Development Goals, health systems and health professionals

25. In his report to the General Assembly last year (A/59/422), the Special Rapporteur emphasized the prominence of health in the Millennium Development Goals. The report set out how the right to health reinforced the health-related Goals and could contribute to their achievement.

26. The right to health requires the development of effective, inclusive health systems of good quality — precisely what is needed for the achievement of the Goals. For its part, the United Nations Millennium Project consistently emphasizes the importance of building health systems that provide universal access to essential health services — consider, for example, *Investing in Development: A Practical Plan to Achieve the Millennium Development Goals*, as well as the compelling Task Force report *Who's Got the Power? Transforming Health Systems for Women and Children*.

27. Critically, an effective health system depends upon health professionals. Yet human resources are in crisis in many health systems. In many countries, health workers are in "a precarious condition".[15] The HIV/AIDS epidemic increases the work burden, sickening and killing health workers, and stigmatizing those who care for patients. Many health-care systems have been neglected and suffer from more than two decades of underinvestment. The skills drain is hitting many developing countries hard, especially in sub-Saharan Africa.

28. For these and other reasons, there is "a massive global shortage of health workers", equivalent to about 4 million health professionals.[16] Experts estimate that if sub-Saharan countries are to come close to approaching the health-related Millennium Development Goals, they must triple their current health workforce by adding about 1 million health professionals.[17] In short, if the international community is serious about achieving the Goals, it has to be serious about health systems, health professionals, and the skills drain.

29. The dimension of the skills drain that is the focus of this report, namely the migration of health professionals from developing to developed countries, is both complex and varied. The phenomenon is experienced differently in different countries; also, it can be experienced differently within different parts of the same country. The Special Rapporteur recognizes that the migration of health professionals from developing to developed countries may have positive effects, not only for the migrants themselves but also for developing countries. If the migrants return, for example, the professional experience they have gained overseas can enhance their contribution to health systems in countries of origin. In some cases,

migrants' remittances make a major contribution to the economies of countries of origin although, significantly, that does not mean the funds are invested in those countries' health systems.

30. Numerous policy responses have been suggested, and sometimes implemented, in response to the negative impacts of the skills drain. The aim of this chapter is not to examine these policy options in detail, although some are briefly considered. Rather, the chapter's objective is more modest: to provide a brief introduction to the skills drain from the perspective of the right to health and to emphasize that the skills drain is a serious right to health issue, especially for those living in poverty in countries of origin.[18]

C. The problem

31. Health professionals tend to migrate from poorer to richer regions or countries. Source countries for international migration are mainly in Africa, the Caribbean, South-East Asia and South Asia, with their workers moving to destination countries including Australia, the United States, the United Kingdom, Canada, France and Belgium.[19]

32. The problem is most acute for source countries with low densities of health professionals, or understaffed health sectors, in particular countries in sub-Saharan Africa. In Malawi, only 1,842 of 6,620 established posts for nurses are filled.[20] Thirty-four, mainly sub-Saharan African countries have fewer than 10 doctors per 100,000 population.[21] This compares with much higher densities in high-income countries. OECD countries average around 222 doctors per 100,000 population.[22] Sub-Saharan Africa has a tenth of the nurses and doctors for its population that Europe has.[23]

33. There are also dramatic differences between rural and urban areas. In Ghana, for example, more than 85 per cent of general physicians work in urban regions, although 66 per cent of the population lives in rural areas. In Bangladesh, metropolitan centres have 15 per cent of the population, but 35 per cent of the doctors and 30 per cent of the nurses.[24]

34. Yet health professionals from developing countries, including sub-Saharan countries, are increasingly migrating to take up employment in developed countries. The South African Medical Association estimates that at least 5,000 South African doctors have moved abroad, mostly to the United States, Canada, the United Kingdom and Australia.[25] An estimated 30-50 per cent of health graduates leave South Africa for the United States and the United Kingdom each year. In 1999, Ghana lost more nurses than it trained. Between 1998/99 and 2001/02, in the United Kingdom there was a dramatic increase in registration of nurses from Zimbabwe (52 to 368) and from Malawi (1 to 75).[26] Other countries are also affected. For example, during the 1990s, two thirds of Jamaica's nurses left the country permanently.[27]

35. The loss of health professionals is particularly acute in the English-speaking world. In France (a country whose language is also widely used in medical education) only 5 per cent of practising doctors qualified overseas.[28] In Canada, the United States and Australia, over 20 per cent of doctors qualified overseas, while in the United Kingdom and New Zealand the figure is over 30 per cent.[29]

D. Reasons for the skills drain: "push" and "pull" factors

36. The complex and varied reasons causing the migration of health professionals are often framed as "push" and "pull" factors. Many of these factors are closely related to inequalities between, and within, countries.

37. Push factors often include terms and conditions at work, such as poor remuneration; inequitable salary structures; long working days; unsafe working environments; poor management of health personnel; and fragile health systems where health professionals often lack medicines, equipment and supplies that enable them to help their patients. In many countries, in particular in sub-Saharan Africa, HIV/AIDS is a particular burden on the workforce, increasing the number of patients, diminishing human resources where health personnel have died or become ill with the disease, and creating additional responsibilities for health professionals who have to care for family members. Shortages of health professionals exacerbate pressures on staff. A lack of training and career opportunities also leads to the migration of health workers. Many of these problems are experienced most severely in underresourced health systems.

38. Other push factors, largely external to the health system, include abuses of civil and political rights, lack of security, and poor educational provision and a low standard of living.

39. Pull factors include the inverse of many push factors — higher salaries; enhanced career or educational prospects; better working conditions and political and economic stability in countries of destination. Some health professionals who have migrated report that immigration restrictions make it difficult for them to circulate between their country of origin and destination. An important pull factor is demand in developed countries where there are inadequate numbers of health workers compared to health-care needs arising from poor retention rates, inadequate numbers of health professionals being trained and increasing health-care demands. It is estimated that by 2020, the United States will face a shortfall of 85,000 to 200,000 physicians, and may face a shortage of over 800,000 nurses.[30] And it is estimated that England will need 25,000 more doctors and 250,000 more nurses by 2008 than it did in 1997.[31]

40. Migration flows are also influenced by a host of other factors. International integration, and commercialization, of health services has created new opportunities for health workers to seek employment beyond their countries of origin and in the private sector.[32] Improved telecommunications have raised awareness among health professionals of opportunities overseas. Also significant are the activities of recruitment agencies, which recruit on a large scale (e.g. groups of 20, 50 or 100 nurses at a time) in developing countries, and often smooth the process of migration.[33] Loans, which ease the migration process, are also more widely available to migrants. The GATS may facilitate and lead to an increase in migration of health professionals in the future.[34]

E. The skills drain, human rights and the right to health

41. Broadly speaking, three clusters of human rights are especially relevant to the dimension of the skills drain that is the focus of this report, i.e. the migration of health professionals from developing to developed countries:

(a) The right of everyone to liberty of movement, as well as the freedom to leave any country including one's own;

(b) Labour rights — the rights to and in work;

(c) The right to the highest attainable standard of health, which encompasses a right to an effective and inclusive health system of good quality.

42. In the context of the present discussion, (a) and (b) are especially relevant to health professionals. Importantly, (c) is especially relevant to individuals and communities in countries of origin and destination.

43. There are some key features of the international code of human rights which are integral components of one or more of these clusters of rights: non-discrimination, participation, international assistance and cooperation, and accountability. Additionally, some other human rights are relevant to the skills drain, such as the rights to an adequate standard of living and to education.

44. For a number of reasons, not least the scope of the Special Rapporteur's mandate, the following discussion focuses on the right to the highest attainable standard of health (i.e. (c) above), while also encompassing the key generic human rights features of non-discrimination, participation, international assistance and cooperation, and accountability.[35]

45. As already signalled, the skills drain bears upon the right to the highest attainable standard of health in both countries of origin and destination. Here, however, the Special Rapporteur emphasizes the impact of the skills drain on the enjoyment of the right to health in developing countries of origin. In his experience, the voices of individuals and communities in these countries are least likely to be heard. It is their human rights that are most frequently overlooked. Thus, it is the right to health of individuals and communities in developing countries of origin to which he gives particular attention.

1. Freedom of movement

46. International human rights law recognizes the right of everyone to liberty of movement, as well as the freedom to leave any country, including his or her own.[36] In other words, health professionals have a right to leave their country, should they wish to do so. Many health professionals exercise this right with a view to living and working in an environment that enables them to enjoy their other economic, social, cultural, civil and political rights.

2. Labour rights

47. Poor terms and conditions of work are a primary cause of health professionals seeking to migrate. However, while migration often helps health professionals enhance their terms and conditions of work, as well as their enjoyment of other human rights, migration sometimes has negative implications for the labour rights of some migrants.

48. Recruitment agencies may exploit and reinforce unrealistic expectations among migrant health professionals about the extent and nature of working opportunities overseas.[37] Unscrupulous employers sometimes withhold or confiscate migrants' identity papers. There is evidence of discrimination against migrant health workers in relation to career opportunities.[38] Many migrant health professionals are

women who face discrimination based on their gender, as well as their national origin, race, ethnicity and migrant status.

49. Migrants' rights to, and in, work are firmly entrenched in numerous international labour conventions, the International Covenant on Economic, Social and Cultural Rights, the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families and other international instruments.

3. The right to health

50. An extensive and nuanced body of international and national law elaborates the scope of the right to health. In his various reports, the Special Rapporteur has begun to set out and examine this law and practice. He will not repeat this exercise here. Instead, for ease of reference, he provides a brief introduction to the right to health.

51. Adopted in 1946, the Constitution of the World Health Organization recognizes the fundamental human right to health. Two years later, the Universal Declaration of Human Rights laid the foundations for the international legal framework for the right to health. Since then, the right to health has been codified in numerous legally binding international and regional human rights treaties. The most extensive treaty elaboration of this right is in the Convention on the Rights of the Child, which has been ratified by all States, bar two. Further, these binding treaties are beginning to generate case law and other jurisprudence that sheds light on the content of the right to health. The right to health is also enshrined in numerous national constitutions: over 100 constitutional provisions include the right to health, the right to health care, or health-related rights such as the right to a healthy environment. Moreover, in some jurisdictions constitutional provisions on the right to health have generated significant jurisprudence, such as the South African Constitutional Court case *Minister of Health and Others v. Treatment Action Campaign and Others*.[39]

52. As already mentioned, the right to health includes the right to health care, but it goes beyond health care to encompass safe drinking water, adequate sanitation and access to health-related information, including on sexual and reproductive health. The right includes freedoms, such as the right to be free from involuntary sterilization, as well as to be free from discrimination in health programmes and services. It also includes entitlements, such as the right to a system of health protection. The right has numerous elements, including child health, maternal health and access to essential drugs. Like other human rights, it has a particular preoccupation with the disadvantaged, the vulnerable and those living in poverty. The right requires an effective, inclusive health system of good quality.

53. Although subject to progressive realization and resource availability, the right to health imposes some obligations of immediate effect, such as non-discrimination. It demands indicators and benchmarks to monitor the progressive realization of the right. The right to health also encompasses the active and informed participation of individuals and communities in health decision-making that affects them. Under international human rights law, developed States have some responsibilities towards the realization of the right to health in poor countries. Because the right to health gives rise to entitlements and obligations, it demands effective mechanisms of accountability.

54. It is self-evident that it is impossible to realize a vital dimension of the right to health — to establish an effective inclusive health system of good quality — without a minimum number of health professionals.

55. Some of the relevant facts and figures have already been mentioned and they will not be repeated. In parts of some countries, even the most rudimentary health system is barely functioning. Where they are functioning, some health systems are — in reality — inaccessible to millions of those living in poverty. Yet in some of these countries health professionals are being trained at considerable public expense, only to leave and work in countries that already enjoy among the finest health systems in the world. In other words, in some countries the skills drain is helping to turn a health crisis into a health catastrophe.

56. In his previous reports, the Special Rapporteur has been developing a common way of approaching elements of the right to health with a view to making them easier to understand. He has applied this common approach to sexual and reproductive health rights (see E/CN.4/2004/49) and to mental disability (see E/CN.4/2005/51). For example, one part of the common approach is to see the right to health as a bundle of health services, goods and facilities which must be available, accessible, acceptable and of good quality within a country. Applying this aspect of the common approach to the skills drain underlines that a State must ensure that an adequate number of health professionals are available in the country, accessible to all, including those living in poverty in the rural areas, and delivering health services of good quality in a culturally acceptable manner.

(a) Participation

57. Participation is an integral feature of the right to health. It extends to the active and informed participation of individuals and communities in decision-making that affects them, including decisions that relate to health, such as those that impact upon the skills drain. In other words, the right to health not only attaches importance to achieving health-related objectives, but also to the processes by which they are achieved.

58. In relation to policymaking which impacts upon the skills drain, efforts should be made to ensure the participation of all relevant stakeholders, including health professionals (e.g. those who have migrated, may migrate, and those that remain), as well as health system users in countries of origin. Such participation is likely to depend upon participants' representative organizations, such as health professional associations and patients' groups.

(b) International assistance and cooperation

59. In addition to obligations at the domestic level, States have a responsibility deriving from, inter alia, article 2, paragraph 1, of the International Covenant on Economic, Social and Cultural Rights and article 4 of the Convention on the Rights of the Child to take measures of international assistance and cooperation towards the realization of economic, social and cultural rights, including the right to health. This responsibility, which is particularly incumbent on developed States, also arises in the context of commitments made at recent world conferences, including the Millennium Summit, and to Millennium Development Goal 8 (see A/59/422).

60. Like other human rights and responsibilities, the parameters of international assistance and cooperation are not yet clearly drawn. However, as the next paragraphs illustrate, international assistance and cooperation is not simply a matter of developed countries making funds available to developing countries. In the context of the right to health and the skills drain, the human rights responsibility of international assistance and cooperation encompasses a number of dimensions, including the following.

61. First, developed countries should respect the right to health in developing countries. For example, developed countries should ensure that their human resource policies do not jeopardize the right to health in developing countries. If a developed country actively recruits health professionals from a developing country that is suffering from a shortage of health professionals in such a manner that the recruitment reduces the developing country's capacity to fulfil the right to health obligations that it owes its citizens, the developed country is prima facie in breach of its human rights responsibility of international assistance and cooperation in the context of the right to health. Some countries have developed policies that reflect this principle.[40]

62. Second, States should take all reasonable measures to prevent third parties from jeopardizing the enjoyment of the right to health in other countries, so far as they are able to influence such third parties by way of legal or political means.[41] For example, States should regulate private recruitment agencies that operate internationally with a view to ensuring that they do not recruit in a manner that reduces a developing country's capacity to fulfil the right to health obligations that it owes to those within its jurisdiction.

63. Third, States should ensure that the right to health is given due attention when drafting and implementing international agreements, for example, when negotiating their scheduled commitments under GATS mode 4 (which concern, inter alia, health professionals temporarily entering another country to provide a health service). In a previous report, the Special Rapporteur observes that if increased trade in services were to lead to substandard health facilities, goods and services, this would prima facie be inconsistent with the right to health (E/CN.4/2004/49/Add.1, para. 49). If a State chooses to engage in trade liberalization, including in relation to services, then it should select the form, pacing and sequencing of liberalization that is most conducive to the progressive realization of the right to health for all, including those living in poverty and other disadvantaged groups (ibid., paras. 30 and 46-56). The form, pacing and sequencing of liberalization should be selected on the basis of right to health impact assessments. In this way, a draft mode 4 commitment could be revised, if necessary, so as to ensure that it will not have a negative impact on the right to health of all. Consistent with their responsibility of international assistance and cooperation, developed States should not apply undue pressure on developing countries to make mode 4 commitments that are inconsistent with developing countries' obligations arising from the right to health.

64. Fourth, depending on resource availability, States should provide aid to developing countries so as to facilitate access to essential health facilities, goods and services, especially for those living in poverty and other disadvantaged groups. Aid policies should include support for human resources in the health sector.

65. However, the central point is that it is disingenuous for developed countries to provide overseas development assistance, debt relief and other forms of

international assistance and cooperation to developing countries, while simultaneously hiring health professionals who have been trained at the expense of, and are desperately needed in, the developing countries of origin. What is the point of giving with one hand and taking with the other?

(c) Accountability

66. International human rights empower individuals and communities by granting them entitlements and placing legal obligations on others. Critically, rights and obligations demand accountability: unless supported by a system of accountability they can become no more than window dressing. Accordingly, a human rights — or right to health — approach emphasizes obligations and requires that all duty holders be held to account for their conduct.

67. All too often, "accountability" is used to mean blame and punishment.[42] But this narrow understanding of the term is much too limited. A right to health accountability mechanism establishes which health policies and institutions are working and which are not, and why, with the objective of improving the realization of the right to health. Such an accountability device has to be effective, transparent and accessible.[43]

68. In the context of the skills drain, national and international accountability mechanisms are needed in relation to the discharge of the various human rights obligations of the various actors. For example, national mechanisms should monitor the human rights of health professionals in their countries of origin. In countries of destination, national mechanisms should monitor the human rights of health professionals, including migrants. Also, international accountability mechanisms, such as treaty bodies, should consider the human rights of health professionals in countries of origin and destination.

69. However, these national and international accountability mechanisms should not only encompass the human rights of health professionals, they should also consider the impact of the skills drain on relevant health systems. In other words, the mechanisms should consider the impact of the skills drain on the enjoyment of the right to health of individuals and communities in both countries of origin and destination. It is necessary to develop indicators and benchmarks to monitor the right to health dimensions of the skills drain, including the responsibilities of countries of origin and destination (see A/58/427 and A/59/422 for the Special Rapporteur's approach to this question).

70. Here, an important point demands emphasis. There is a long-standing perception among developing countries that accountability arrangements are imbalanced and mainly applicable to them, while developed countries escape accountability when failing to fulfil their international pledges and commitments that are of particular importance to developing countries.[44]

71. There is no doubt that national and international accountability mechanisms in relation to developed countries' responsibility of international assistance and cooperation remain weak. For example, there are few (if any) national or international mechanisms that give adequate attention to the impact of a developed country's policies on the skills drain and its effect upon the enjoyment of the right to health in countries of origin. This state of affairs is unacceptable because human

rights require effective, transparent and accessible accountability mechanisms in relation to the human rights responsibilities of all actors.

72. In the conclusion to this chapter the Special Rapporteur makes a modest proposal — a national office to monitor international cooperation in health — to address this lacuna in the promotion and protection of the right to health.

F. Some guiding principles

73. Physicians for Human Rights, a non-governmental organization, has recently published a White Paper on the skills drain, entitled *An Action Plan to Prevent Brain Drain: Building Equitable Health Systems in Africa*.[45] Most of the text is a detailed plan of action for addressing the African skills drain. This plan of action is guided by a set of principles that "reflect human rights law and pragmatic concerns".[46] While these guiding principles and a commentary upon them are lengthy, the authors provide a summary of the principles. This summary is reproduced in the next paragraph.

74. The guiding principles provide an interesting contribution to the discussion about the skills drain. In the opinion of the Special Rapporteur, although the principles are neither definitive nor comprehensive (for example, they would be strengthened by the inclusion of principles on monitoring and accountability, as well as the important role of community health workers), they merit careful attention.[47] The principles identified by Physicians for Human Rights are as follows:

- The primary response to the skills drain must be to redress second-class health systems that reflect widespread violations of the right to health and other rights.
- The response must include significantly increased funding to the health sector from domestic and international sources, including debt relief.
- The response to the skills drain must incorporate the broader effort of addressing the unequal distribution of health professionals within countries, including particularly severe shortages in rural areas.
- Low-income countries that are the source of health professionals who migrate to wealthy nations should be reimbursed by those nations.
- Solutions to the skills drain must be locally determined, with participation from representatives of poor and rural communities, health-care workers and civil society.
- Foreign assistance must be structured to promote and enable sound policies on human resources for health.
- The rights of health professionals and their desire to seek a better life must be respected given the constraints and demands of a global public health crisis.
- Countries must adhere to ethical recruitment principles, including not recruiting from developing countries absent an agreement with them.
- High-income countries must address their own inadequate production and retention of health professionals.

- Measures to promote macroeconomic policies must be consistent with human rights.
- Along with increasing retention of skilled health workers, more health professionals must be recruited and trained.
- Capacity-building for health sector human resource management must be a priority.
- Members of the health professional diaspora from developing countries can make an important contribution to health care in developing countries.

G. Conclusion

75. As already mentioned, there are numerous policy responses to the negative impacts of the skills drain, including strengthening health systems in countries of origin, and destination countries strengthening their own domestically trained human resource base. Unfortunately, lack of space does not permit the Special Rapporteur to examine them in detail in this chapter.

76. *Integrate human rights into all skills drain policies.* As the Special Rapporteur has consistently argued since his first report to the Commission on Human Rights, the right to health — and other human rights — should be integrated into all relevant national and international policymaking. Policies that are shaped by human rights are more likely to be effective, robust, equitable, inclusive and meaningful to those living in poverty. Accordingly, human rights should be integrated into all health sector policies, including those bearing upon the skills drain. Attention to the right to health of individuals and communities in developing countries, as well as the human rights of health professionals, will help to address the negative dimensions of the skills drain.

77. *Strengthen health systems in countries of origin.* Consistent with the right to health, one vital policy response to the skills drain is to strengthen health systems in developing countries of origin.[48] A higher priority should be given to human resources in the health sectors of countries of origin, including enhanced terms, conditions, professional development, planning, management and incentives to work in the rural areas. More health professionals are needed, requiring more training resources. Integrated district health systems must be strengthened, their infrastructure upgraded and the role of community health workers enlarged. Governance, including public participation, and effectiveness in the health sector demand serious attention. If the health systems of developing countries of origin are to be strengthened, donors and development partners have an indispensable role to play, as anticipated by numerous international commitments, including the human rights responsibility of international assistance and cooperation.

78. *Ethical recruitment by destination countries.*[49] Since 1999, the United Kingdom Department of Health has gradually strengthened a Code of Practice for the international recruitment of health-care professionals.[50] Ethical codes of practice have been promoted by several international and professional organizations.[51] So far as the Special Rapporteur is aware, the United Kingdom has gone further than any other developed country in its attempts to implement an ethical code. To the Government's credit, the Code recognizes, and attempts to address, the negative

impact of its active recruitment of professional staff trained and working in developing countries of origin.

79. Under the Code, the United Kingdom National Health Service may not actively recruit in developing countries unless there is a Government-to-Government agreement that allows targeted recruitment in that country. The Code affirms the employment rights, such as non-discrimination, of health workers from overseas. Compliance with the Code by employers of the National Health Service is not mandatory, but strongly recommended.

80. Although a welcome initiative, from the human rights perspective the Code is flawed. For example, it lacks an independent monitoring mechanism and fails to cover the private sector. Some commentators argue that the Code indirectly discriminates on the grounds of race because it mainly affects health professionals from Africa and the Caribbean.[52] Crucially, there is little evidence of the Code's sustained impact on the rate of recruitment of health professionals from countries with staff shortages.[53]

81. In the view of the Special Rapporteur, while rights-based ethical recruitment policies and codes have a role to play in relation to the skills drain, they do not provide an adequate response and must be supplemented by other measures, including those that strengthen health systems in developing countries of origin.

82. *Compensation*. The migration of health professionals from developing countries where there are staff shortages to developed countries imposes substantial economic and social costs on countries of origin, while saving developed countries' health services significant training costs. The economic name for this process is a "subsidy". The subsidy is perverse because it flows from poor to rich countries, worsening existing global inequalities in health care and protection. This process has been called, inter alia, a "perverse subsidy", an "unjust subsidy" and "reverse foreign aid".[54]

83. As well as being ethically indefensible, this flow of resources from poor to rich is inconsistent with developed countries' human rights responsibility of international assistance and cooperation, as well as other international commitments, including the Millennium Declaration and Goal 8 (a global partnership for development) (see paras. 59-65). There is a compelling case that this perverse subsidy should be redressed by the payment of compensation, restitution or reparation to those developing countries of origin where the skills drain reduces their capacity to fulfil the right to health obligations that they owe their citizens.

84. The call for compensation raises a number of objections and challenges that deserve careful attention. With genuine political commitment, however, they are unlikely to prove insurmountable. Compensation could be paid into a restitution fund that is properly managed and used for specific health purposes agreed by all the parties, such as support for health staff remaining in or returning to the country in question.

85. The Special Rapporteur strongly recommends that when the skills drain amounts to a perverse subsidy the policy response of compensation should be given serious and sympathetic consideration.

86. *A national office to monitor international cooperation on health*. Each developed country should establish an independent national office to monitor the

impact of the Government's policies on the enjoyment of the right to health in developing countries. Along the lines of an ombudsman, the office should report annually to the national legislature. It should have the power to make investigations, conduct inquiries and monitor the Government's international commitments and pledges on health matters. Responsibility for these international health commitments is often spread across various ministries — health, finance, foreign affairs, trade, international development and so on — thereby complicating both coordination and accountability.[55]

87. One of the health issues that the office should monitor is the skills drain. In many countries, there is a dearth of reliable data on the skills drain, so one of the office's tasks would be to ensure that the Government collects the necessary data. What is the extent of the skills drain in the country in question? Which national policies are impacting upon the skills drain? What is the impact of the skills drain, especially in the countries of origin? How might national policies be revised to make them consistent with the Government's human rights responsibilities, including international assistance and cooperation for health? An ombudsman-style office that asks these sorts of questions would complement and strengthen existing accountability mechanisms, such as parliamentary subcommittees.

88. The office might also serve as a watchdog for national codes of conduct on ethical recruitment, such as the one adopted by the United Kingdom National Health Service, as well as national implementation of comparable international codes, such as the Code of Practice for the International Recruitment of Health Workers adopted by the Commonwealth Secretariat in 2003.

89. *A multidimensional response.* Because of its complexity, the international migration of health professionals requires a multidimensional response, some elements of which are signalled in this chapter. The skills drain has to be understood, however, in the context of the alarming inequality in levels of health care and protection in the contemporary world.

V. Conclusion

90. A recurrent theme throughout this report is the indispensable role of health professionals in the promotion and protection of human rights, including the right to health. Human rights education helps health professionals defend the rights of their patients, as well as their own human rights. The skills drain — developed countries employing health professionals trained at the expense of, and desperately needed in, developing countries — undermines the enjoyment of the right to health in the countries of origin and deepens global health inequality. If the Millennium Development Goals are to be achieved, and effective inclusive health systems of good quality are to be established, it is imperative that the situation of health professionals, including the skills drain, is given urgent attention.

Notes

[1] For example, see article 12 (2) (b) of the International Covenant on Economic, Social and Cultural Rights and article 24 (2) (c) of the Convention on the Rights of the Child.

[2] See for example the reports of the Special Rapporteur on his missions to Peru (E/CN.4/2005/51/Add.3) and Romania (E/CN.4/2005/51/Add.4).

[3] See Commonwealth Medical Trust (Commat), *A Training Manual of Ethical and Human Rights Standards for Health Care Professionals*, 1999.

[4] Resolution on the Inclusion of Medical Ethics and Human Rights in the Curriculum of Medical Schools Worldwide, adopted by the 51st Annual General Assembly of the World Medical Association (October 1999).

[5] See http://www.icn.ch/pshumrights.htm.

[6] CEDAW, general recommendation 24 (1999) on women and health, para. 31 (f).

[7] See, for example, Commat, op. cit. at note 3; Johannes Wier Foundation, *Health and Human Rights: A Course for Doctors, Nurses, and Paramedics* (in Training), 1996; J. Asher, *The Right to Health: A Resource Manual for NGOs*, Commat/AAAS, 2004; Norwegian Medical Association, *Doctors working in Prisons: Human Rights and Ethical Dilemmas, A Course for Prison Doctors* (http://lupin-nma.net); Physicians for Human Rights-UK, *Medicine and Human Rights Study Module* (http://phruk.shared-inter.net/module/index.php). Note also the International Human Rights Academies, focusing on the right to health, organized by the International Federation of Health and Human Rights Organizations and others in 2004 and 2005, and the annual intensive course on health and human rights organized by the François-Xavier Bagnoud Centre for Health and Human Rights, Harvard University, and others.

[8] See British Medical Association (BMA), *The Medical Profession and Human Rights: Handbook for a Changing Agenda*, BMA/Zed Books, 2001, p. 490.

[9] In this report, the Special Rapporteur has made particular use of research carried out on the skills drain in certain countries and regions, notably sub-Saharan Africa, the United Kingdom and the United States. He emphasizes, however, that the skills drain is a global problem and not confined to these regions and countries of origin and destination.

[10] K. Mensah, M. Mackintosh and B. Henry, The "Skills Drain" of Health Professionals from the Developing World: A Framework for Policy Formulation, Medact, 2005, p. 5.

[11] Resolutions WHA57.19 and WHA58.17, International migration of health personnel: a challenge for health systems in developing countries.

[12] For example, see O. Adams and B. Stilwell, Health Professionals and Migration. *Bulletin of the World Health Organization*, vol. 8, August 2004, p. 560; L. Chen et al. Human Resources for Health: Overcoming the Crisis, *The Lancet*, vol. 364, 27 November 2004, pp. 1984-1990; EQUINET, Health Systems Trust and Medact, Health Personnel in Southern Africa: Confronting Maldistribution and Brain Drain, 2003; Joint Learning Initiative (JLI), Human Resources for Health: Overcoming the Crisis, 2004; Mensah, Mackintosh and Henry, op. cit. at note 10; Physicians for Human Rights (PHR), An Action Plan to Prevent Brain Drain: Building Equitable Health Systems in Africa, 2004; A. Willets and T. Martineau, Ethical International Recruitment of Health Professionals: Will Codes of Conduct Protect Developing Country Health Systems? 2004; J. Bueno de Mesquita and M. Gordon, The International Migration of Health Workers: A Human Rights Analysis, Medact, 2005; WHO, International Migration, Health and Human Rights, 2003.

[13] Sponsored by PHR. Also see "Medical staff quit for the West, leaving Africa's health service in crisis", The *Independent*, 27 May 2005.

[14] Group of eight (G-8) Summit, "Statement on Africa (Africa: A Historic Opportunity)", Gleneagles, Scotland, 8 July 2005.

[15] PHR, op. cit. at note 12, p. vii. A similar analysis is adopted by the Millennium Development Project Task Force on Child and Maternal Health in *Who's Got the Power?*, pp. 120-123.

[16] Chen et al., op. cit. at note 12, p. 1985.

[17] Ibid.

[18] For a more detailed human rights examination of the skills drain than is possible here, see in particular Bueno de Mesquita and Gordon, PHR and WHO, op. cit. at note 12.

[19] JLI, op. cit. at note 12.

[20] J.-M. Aitken and J. Kemp, HIV/AIDS, Equity and Health Sector Personnel in Southern Africa, EQUINET and Oxfam, 2003, p. 20.

[21] WHO Global Health Atlas, http://www.who.int/globalatlas/dataQuery/default.asp. Data from 2004.

[22] PHR, op. cit. at note 12.

[23] Chen et al., op. cit. at note 12.

[24] JLI, op. cit. at note 12.

[25] South Africa: Government wakes up to flight of health workers, IRIN, 14 May 2002.

[26] PHR, op. cit. at note 12.

[27] Bueno de Mesquita and Gordon, op. cit. at note 12.

[28] J. Eastwood et al., "Loss of health professionals from sub-Saharan Africa: the pivotal role of the UK", *The Lancet*, vol. 365, Issue 9474, 28 May 2005.

[29] JLI, op. cit. at note 12.

[30] See "Medical miscalculation creates doctor shortage", *USA Today*, 3 February 2005; United States Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions, National Center for Health Workforce Analysis, *Projected Supply, Demand, and Shortage of Registered Nurses: 2000-2020*, 2002.

[31] Addressing Africa's Health Workforce Crisis: An Avenue for Action, background paper presented at the second High-level Forum on the Health MDGs, Abuja, 2-3 December 2004.

[32] Mensah, Mackintosh and Henry, op. cit. at note 10.

[33] PHR, op. cit. at note 12.

[34] It should be noted that GATS mode 4 is intended to facilitate temporary migration. Eastwood et al., op. cit. at note 28.

[35] All of these key generic features are given separate consideration below except discrimination, which is integrated throughout the text.

[36] International Covenant on Civil and Political Rights, art. 12.

[37] "Abused, threatened and trapped: Britain's foreign 'slave nurses'", *The Guardian*, 29 May 2001; Foreign Doctors, BBC News Online, United Kingdom edition, 8 September 2004.

[38] K. Decker, Overseas Doctors: Past and Present, in *Racism in Medicine: An Agenda for Change*, N. Coker (ed.), King's Fund, 2001; D. Singh, "Racism rife in the medical professional, BMA report says", *British Medical Journal*, vol. 326, 28 June 2003, p. 1418.

[39] Constitutional Court of South Africa, Case CCT 8/02, decided 5 July 2002.

[40] See for example United Kingdom Department of Health, Code of Practice for the International Recruitment of Health Professionals, 2004; see paras. 78-80 below for a discussion of the Code.

[41] Committee on Economic, Social and Cultural Rights, general comment No. 14, para. 39.

[42] See L. P. Freedman, "Human rights, constructive accountability and maternal mortality in the Dominican Republic: a commentary", *International Journal of Gynaecology and Obstetrics*, vol. 82, 2003, pp. 111-114.

[43] The accountability device should clarify who has the responsibility to do what — and whether they have done it. If they have not done it, the device should explore why not, with a view to ensuring that it is properly done next time. For more on accountability, see A/59/422, para. 38.

[44] United Nations Development Programme, Bureau for Development Policy, *Is MDG 8 on track as a global deal for human development?* by J. Vandenmoortele, K. Malhotra and J. A. Lim, 2003.

[45] PHR, op. cit. at note 12.

[46] Ibid., p. 29.

[47] The Special Rapporteur has declined to revise the guidelines, save to change "brain drain" to "skills drain" and to extend the last guideline beyond Africa to all developing countries.

[48] *Who's Got the Power?*; PHR and Bueno de Mesquita and Gordon, op. cit. at note 12.

[49] Willets and Martineau, op. cit. at note 12; Mensah, Mackintosh and Henry, op. cit. at note 10; Bueno de Mesquita and Gordon, op. cit. at note 12.

[50] Department of Health, op. cit. at note 42.

[51] E.g. Commonwealth Secretariat, Commonwealth Code of Practice for International Recruitment of Health Professionals, 2002; World Organization of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians (WONCA), A Code of Practice for the International Recruitment of Health Care Professionals, 2002.

[52] Mensah, Mackintosh and Henry, op. cit. at note 10, p. 27.

[53] Ibid., p. 26; PHR, op. cit. at note 12, p. 57.

[54] Mensah, Mackintosh and Henry, ibid., pp. 30-40, Save the Children UK and Medact, *Whose Charity? Africa's Aid to the NHS*, Briefing Paper, 2005; PHR, ibid., p. 31. For discussions of the perverse subsidy see Mensah, Mackintosh and Henry; and also Bueno de Mesquita and Gordon, op. cit. at note 12, from both of which the Special Rapporteur has drawn extensively.

[55] G. Lister, A. Ingram, M. Prowle, "Country Case Study: UK Financing of International Cooperation for Health", United Nations Development Programme, Office of Development Studies, 30 September 2004.

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Human rights questions: human rights situations and reports of special rapporteurs and representatives

Report of the United Nations High Commissioner for Human Rights on assistance to Sierra Leone in the field of human rights

Note by the Secretary-General

The Secretary-General has the honour to transmit to the General Assembly the Report of the United Nations High Commissioner for Human Rights on assistance to Sierra Leone in the field of human rights, submitted pursuant to Commission on Human Rights resolution 2005/76 and decision 2005/276 of the Economic and Social Council.

* A/60/150.

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Summary

The present report follows previous reports of the High Commissioner to the General Assembly (A/59/340), and to the Commission on Human Rights (E/CN.4/2005/113). It contains information on developments from January through to the end of July 2005, including on my visit to Sierra Leone in mid-July.

While progress is being made towards achieving the benchmarks set for the United Nations Mission in Sierra Leone (UNAMSIL) by the end of 2005, peace remains fragile. The critical issues of marginalization and exclusion that were the underlying causes of the conflict and which were identified by the Truth and Reconciliation Commission are yet to be addressed. Other human rights concerns that require continued attention are the protection of the rights of women and protection of children from child labour. Despite the existence of an Anti-Corruption court, corruption is widespread and the judiciary weak. The efforts of the international community to secure the peace in Sierra Leone will be complemented by a significant follow-up human rights presence in the country. There is a need to counteract the climate of impunity and encourage duty bearers to live up to their responsibilities. It is also important that the human rights presence undertakes public reporting on human rights issues, including corruption as an impediment to the enjoyment of economic, social and cultural rights. The international community should encourage African leaders to jointly take a position for the surrender of Mr. Taylor to the Special Court in the interest of both justice and peace.

Sierra Leone has continued to enjoy relative peace and political stability, albeit with substantial international support. The poor state of the economy remains the largest potential threat to peace, stability and the continuous enjoyment of basic human rights and fundamental freedoms under the rule of law. Addressing these problems effectively to prevent possible threats to relative peace in the country remains the most daunting challenge confronting Sierra Leone and its people. The transition from emergency relief to post-conflict recovery and reconstruction has been accompanied by a robust peacebuilding effort by the Government of Sierra Leone jointly with the United Nations through the United Nations Country Team (UNCT) within the framework of the benchmarks and tasks spelled out in Security Council resolution 1562 (2004). This process has also witnessed continued improvements in the human rights situation, especially in the area of civil and political rights.

The decentralization of government and the creation of new local government structures at the district level continue to enhance the participation in governance and the exercise of political rights at the local levels. There are gradual efforts to incorporate some of the international human rights treaties into national law and to establish institutions for the promotion and protection of human rights. The Government released the "White Paper on the Truth and Reconciliation Project" response to the report of the Truth and Reconciliation Commission, accepting in principle to implement the recommendations of the Commission. Although Parliament passed an act on the establishment of a national independent human rights commission, as provided for in the Lomé Peace Agreement, it has not been established. The Special Court remains functional, and the trials of those indicted for war crimes are continuing, but the Court faces a number of challenges, including funding.

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I. Introduction

1. The Commission on Human Rights, in its resolution 2005/276, requested the United Nations High Commissioner for Human Rights to report to the General Assembly at its sixtieth session and to the Commission at its sixty-second session on assistance to Sierra Leone in the field of human rights, including with reference to reports from the Human Rights Section of the United Nations Mission in Sierra Leone (UNAMSIL).

II. The human rights situation

A. Reports of the Secretary-General and the United Nations High Commissioner for Human Rights

2. Since the High Commissioner for Human Rights submitted a report on assistance to Sierra Leone in the field of human rights to the General Assembly at its fifty-ninth session (A/59/340), the Secretary-General has submitted the twenty-third (S/2004/724), twenty-fourth (S/2004/965), and twenty-fifth (S/2005/273 and Add.1-2) reports on UNAMSIL to the Security Council, as well as a report on inter-mission cooperation and possible cross-border operations between UNAMSIL, the United Nations Mission in Liberia (UNMIL), and the United Nations Operation in Côte d'Ivoire (UNOCI) (S/2005/135).

3. In his twenty-third report, the Secretary-General noted improvements in the human rights situation but indicated that they were undermined by problems in the justice sector concerning a lack of human and material resources and an important backlog of cases.

4. In his twenty-fourth report, the Secretary-General noted that while the overall human rights situation in the country continued to improve under a stable general security environment, the socio-economic situation in the country remained a serious challenge to prospects of national recovery. The Secretary-General also reported on the submission of the final report of the Truth and Reconciliation Commission to the President, Ahmad Tejan Kabbah, and on the agreement signed by the Special Court on the enforcement of sentences, which will allow some of those convicted to serve their sentences outside Sierra Leone.

5. In his report on inter-mission cooperation and possible cross-border operations between UNAMSIL, UNOCI and UNMIL, the Secretary-General noted that the root causes as well as the effects of the conflicts in Côte d'Ivoire, Liberia and Sierra Leone were intricately linked, and that restoration of peace in the subregion required that a number of key issues be addressed at both the national and subregional level. UNAMSIL, UNMIL and UNOCI should enhance cooperation in the area of human rights.

6. In his twenty-fifth report, the Secretary-General reported that progress towards the building of national capacity in human rights protection and promotion continued. Although a culture of respect for human rights had not yet taken root, there had been no serious violations of human rights and humanitarian law.

7. By its resolution 1610 (2005) of 30 June 2005, the Security Council extended the mandate of UNAMSIL until 31 December 2005.

B. Right to life and security of the person

8. The general trend is towards a greater respect for the right to life and security of the person. There are no reports of arbitrary killings, extrajudicial executions or a persistent and pervasive pattern of gross human rights violations in the country. Allegations of such violations are routinely investigated and perpetrators prosecuted in accordance with the law.

9. However, the Government's response to some civil and political issues such as boundary disputes, complaints against paramount chiefs or complaints arising out of chieftaincy elections, have not been dealt with timely or in accordance with any transparent process. Most disturbing is the perennial "Yenga issue", a border dispute on the precise demarcation of the boundary between Sierra Leone and Guinea. The residents of several villages and towns along the border, historically part of Sierra Leone, have been forced to abandon their homes and property and to flee to surrounding towns and villages due to harassment and intimidation by Guinean soldiers. In April 2005, five United Nations military observers were arrested briefly and their cameras confiscated by Guinean soldiers when they ventured into one of the border villages in the Kambia district.

10. The death penalty is still part of national law and there are 21 persons including two women on death row at the Pademba Road Prison in Freetown. In its report submitted to the President on 5 October 2004, the Truth and Reconciliation Commission recommended the abolition of the death penalty. Regrettably, in the "White Paper on the Truth and Reconciliation Project" published on 28 June 2005, the Government rejected this call affirming that it will only take recourse to this remedy for the most serious crimes.

11. After prolonged delays, the prosecution of the 67 ex-combatants of the former Revolutionary United Front (RUF) and 34 "West-side Boys" detained since 2002 has commenced and is still in progress.

12. There are no political prisoners in detention. However there is one journalist serving a prison term, convicted under a law that criminalizes conduct growing out of the exercise of the rights of freedom of expression. The Truth and Reconciliation Commission report recommended the abolition of laws that criminalize conduct growing out of the exercise of free speech.

C. Amputees

13. One of the notorious characteristics of the Sierra Leone conflict was the mutilation and amputation of civilians. The reintegration of those wounded during the war remains a daunting challenge. Many of the amputees and wounded, further handicapped by the lack of basic services, especially proper medical care, clean drinking water and adequate educational facilities for their children, have been reduced to beggars on the streets of Freetown and other major towns across the country.

14. Many of the amputees and wounded are accommodated in camps set up by the Norwegian Refugee Council under a housing and resettlement project for amputees and wounded. The World Food Programme (WFP) and international non-governmental organizations (NGOs) supported amputees and wounded in these camps with food rations, non-food items and medical services up to June 2004. The

absence of support to these camps has seen a gradual reduction in the number of inmates. Aberdeen Camp with an original population of 230 registered amputees in 1999 has now only 37. The population of Grafton, located in the outskirts of Freetown, has declined from 115 to 75.

15. I will continue to urge the Government of Sierra Leone to give priority attention, in cooperation with the international community, to the development and implementation of programmes aimed at addressing the special needs of victims of mutilations and their dependants, especially of women and children in their care, and in particular those sexually abused and/or gravely traumatized. In its report, the Truth and Reconciliation Commission recommended a reparation package for the amputees and wounded, providing for their needs in the areas of health, pensions, education, skills training and microcredit. Although the Government accepted these recommendations, it limits its implementation to the availability of resources and support from the international community.

D. Children's rights

16. Some progress has been made in the implementation of children's rights. Almost all abducted and separated children have been reunited with their families. Through the assistance of UNAMSIL, United Nations Children's Education Fund (UNICEF) and other donors, schools continued to be constructed or rehabilitated, and many children have returned to school. UNAMSIL continued to give voice to children through a regular radio programme, the Voice of Children. However, children still remain vulnerable in Sierra Leone. The synergistic effect of traditional practices, illiteracy, poverty and the lack of adequate educational facilities, coupled with the absence of basic social services, continues to deny many children the rights and freedoms to which they are entitled under the Convention on the Rights of the Child. The situation is particularly serious in the case of the girl child. Not only do girl children continue to be subjected to traditional practices such as female genital mutilation, but many are not sent to school or are prematurely removed from school and subjected to early and forced marriages. In many parts of the country, girls under 14 are forced into marriages with men old enough to be their fathers and grandfathers. The girl child's right to express herself in such settings is severely restricted by tradition and culture. Hence they continue to suffer in silence.

17. Another major obstacle to the realization of the rights of children is the high dropout rate at the secondary school level, especially of girls. This is exacerbated by the scarcity of post-primary schools in rural areas leading to limited opportunities for education beyond primary level. Children graduating from elementary schools in many rural areas are forced to relocate to other areas to attend secondary school or to walk for long hours to and from schools in neighbouring towns. This exposes them to various hazards, including rape and other forms of sexual violence. Especially in rural areas, parents prefer using their children particularly girls for house chores or as farm hands rather than sending them to school.

18. The Government is currently implementing a policy aimed at providing free education and school materials to girls attending secondary schools in the northern and eastern provinces. The Government-led campaign, "send your girl child to school" and the "United States Girl Child Education Scholarship pilot programme" targeting 3,000 girls of primary school age in Port Loko, have emerged as important

tools in the war against early and forced marriages and in support of girl child education. Other positive initiatives in this area have been undertaken by the Forum for African Women Educationalists (FAWE), Plan Sierra Leone, and the International Development Agency. The African Development Bank sponsored the SABABU Education Project, aimed at rehabilitating basic education facilities and providing basic skills training to children until 2007, is also commendable. Nevertheless, there are still a large number of children who do not have access to basic education due to the absence of educational facilities, logistics and supplies, as well as trained and qualified teachers.

19. Child neglect, child abuse and sexual assault remain perennial problems in Sierra Leone. Reports from the Child Protection office of UNAMSIL show an increase in reported cases of sexual abuse against children, in some cases as young as six years old. The NGO Cooperazione Internazionale (COOPI) recorded 1,000 victims of sexual abuse in Kono District and Western area between April 2002 and June 2005. UNICEF is supporting the International Rescue Committee to provide medical treatment and counselling for the victims. The Government is encouraged to extend to rural communities the practice of establishing family support units in police stations.

20. The juvenile justice system remains an area of concern. There are continuing reports of juveniles arrested, detained in police cells, tried in open court and sentenced to jail terms without the involvement of probation officers of the Ministry of Social Welfare, Gender and Children Affairs, and in violation of the Joint Protocol signed by the police and the Ministry. In Makeni, for instance, a 14-year-old boy was charged with stealing 11,000 Leones (approximately US$ 4). Without legal counsel, and without either the parents of the child or the probation department of the Ministry being notified, the child was tried by the Magistrate Court in Makeni in April 2005, convicted and sentenced to 18 months imprisonment. It took the intervention of the UNAMSIL Human Rights Section and the Bombali Human Rights Committee for the sentence to be overturned and the child released.

21. Another problematic area is the non-separation of juvenile and adults in detention facilities and prisons as well as the emphasis on incarceration for juvenile offenders. UNICEF is funding Defence of Children International, an NGO to provide training for staff of departments involved in juvenile justice and to emphasize alternatives including diversion to the traditional judicial processes. UNICEF has also provided funding to the Ministry of Social Welfare, Gender and Children Affairs to facilitate bail for children in conflict with the law in districts where there are no remand homes or approved rehabilitation facilities.

22. As indicated in my last report, there is only one remand home and one approved correctional school for juveniles in Sierra Leone. Both facilities are located in Freetown and do not meet minimum international standards. A second remand home built in Bo, with funding from UNAMSIL and UNICEF is still under construction. The only existing approved correction school was established in 1947 with a capacity for 150 inmates but currently has no educational facility, running water or fence. The children are fed once a day. Hence, many of them routinely abscond never to return.

23. Human trafficking, especially of children, both externally and internally is still a serious issue in Sierra Leone. The civil war created a situation where children became particularly vulnerable to trafficking. The Government has shown some

readiness in addressing the issue, and Parliament passed an anti-trafficking bill. Human rights NGOs, in collaboration with UNAMSIL Human Rights Section have launched awareness-raising and sensitization activities, inter alia, by organizing workshops and advocacy in the mass media.

24. Child labour continues to be a problem. Children continue to be lured into working in diamond areas, including in underground mines, for long hours with low wages and in hazardous conditions.

25. Street children, another legacy of the decade armed conflict in Sierra Leone remains a serious scourge. They lack parental care and support and roam the streets of Freetown, begging for alms or engaging in prostitution or other forms of criminal activities. The large number of street children is also related to the widespread poverty affecting over 70 per cent of the population, who live on less than one dollar a day. Some special programmes also had been developed by UNICEF and the National Commission for War-Affected Children to address the problem of street children by re-unifying them with their parents through implementing NGOs.

26. Economic planning is seriously constrained by the absence of statistical information in a country where a considerable proportion of the population does not have birth certificates. Some assistance has been provided through a UNICEF programme that registered 23,000 children in Kambia District, Northern Province, and 18,000 in Moyamba district, Southern Province. However, there is a need to extend this programme to the rest of the country and to seek durable solutions.

27. Corporal punishment remains prevalent and is used at home and in schools and imposed by courts. In June 2005, a 12-year-old girl was given 12 lashes on her back in open court upon the orders of a magistrate in Port Loko.

28. The establishment of human rights clubs in secondary schools by the UNAMSIL Human Rights Section has facilitated increased awareness in the communities and among children. Such clubs have been established in five secondary schools in Port Loko District, three in Magburaka District, two in Kabala, Koinadugu District, and four in Kenema. There are plans to establish additional clubs in secondary schools in the remaining eight districts.

29. Legislative initiatives to improve the human rights situation of children have been slow. The child rights bill, prepared with international support is still with the Attorney-General and Minister of Justice and has not yet been introduced in Parliament.

30. The Child Protection Adviser in the Office of the Special Representative of the Secretary-General continued to provide technical advice to the Government on child protection issues and engaged in training and capacity-building in child protection and child rights for the Government, non-governmental institutions and the communities.

E. Gender-based violence and women's rights

31. There has been increased advocacy on women's issues, but this needs to be complemented by concrete legislative action. The Government is currently preparing its initial report to the Committee on the Elimination of Discrimination against Women, although it ratified the Convention in November 1988. The Human

Rights Committee in Parliament, working with civil society organizations and the Government, concluded nation-wide consultations in both Freetown and the provinces on the implementation of the Convention on the Elimination of All Forms of Discrimination against Women. Draft law developed as a result of these consultations is yet to be considered by Parliament. By the same token, a draft bill on sexual offences, prepared by the Law Reform Commission, is still with the Attorney-General and Minister of Justice, and is yet to be presented to Parliament. The Law Commission has embarked on consultations to prepare a law on domestic violence, and is also in the process of finalizing a bill on inheritance, succession and matrimonial laws.

32. The number of those convicted by courts of law for offences related to gender violence continues to rise. Since my last report, nine more convictions have been noted for gender and sex-related violence.

33. In the area of technical assistance, the Division for the Advancement of Women conducted two training programmes for staff of the Ministry of Social Welfare, Gender and Children Affairs and gender focal points from other ministries. The workshops were conducted as follow-up to the mission undertaken in October 2004 by experts from the Committee on the Elimination of Discrimination against Women to assess the implementation of the Convention by the Government of Sierra Leone.

34. Notwithstanding the limited success, cultural and traditional practices and the continuous existence of discriminatory laws against women in several areas continue to undermine the full realization and enjoyment of rights by women. Poverty, which affects women disproportionately, exacerbates the situation. Women continue to be grossly underrepresented in government. Women hold only 11 per cent of seats in the new local government councils. Only 18 out of 124 parliamentarians are women. In the senior ranks of the civil service, only 8 out of 125 are women.

35. Domestic violence, rape and other forms of gender-based violence continue to characterize the life of women in modern Sierra Leone. Customs, tradition and ignorance encourage these violations and abuses, as well as frustrate reporting and investigation by the police. Domestic violence, although widespread in Bombali, Kenema and Kono districts, goes largely unreported by victims in part because of fear of stigmatization. Some victims also refuse to cooperate with the authorities in pressing charges against their abusive spouses. In order to stop and ultimately reverse this trend, the human rights committees in the districts and NGOs, notably the International Rescue Committee, embarked on a public education campaign to raise awareness of women's rights issues. The campaign is being conducted under the auspices of the Ministry of Social Welfare. This campaign is complemented by the establishment of "rainbow centres" by the International Rescue Committee to provide shelter and legal and medical assistance to victims of sexual and gender-based violence. Such centres have been established in Freetown, Koidu and Kenema.

36. Although the "rainbow centres" have been very helpful in responding to the victims of sexual and gender-based violence, their existence is limited to only three locations. There is a need to ensure greater national coverage and wider assistance to victims. In this regard, the Government needs to put in place a comprehensive

system of care for victims of rape and sexual and gender-based violence, which ensures that perpetrators are brought to justice.

37. Another widespread practice, which is sustained by traditional culture practices, is female genital mutilation. Although there has been a longstanding campaign to raise public awareness on this topic, very little progress has been made in reducing its occurrence. There remains a strong need for the Government to enact appropriate legislation to deal with this entrenched scourge.

38. In my last report to the General Assembly, I made reference to the case of a 19-year-old woman allegedly assaulted and killed by UNAMSIL peacekeepers in April 2004 (A/59/340, para. 32). To this date, the investigation has not been concluded and no charges have been preferred. The Board of Inquiry established by UNAMSIL has not submitted its report.

F. Refugees, internees and internally displaced persons

39. Most of the refugees have been repatriated from Guinea and Liberia. However, there is ongoing voluntary repatriation of residual refugee population from neighbouring countries, under the auspices of the Office of the United Nations High Commissioner for Refugees and the National Commission for Social Action. In June 2005, the International Committee of the Red Cross verified 250 unaccompanied Sierra Leonean children in Guinea. One hundred of them have been traced and reunited with their families, while the rest are yet to be traced. ICRC reports that there are an additional 100 children who are staying with relatives in conditions rendering them vulnerable to abuses. A task force comprising UNICEF, the Ministry for Social Welfare and UNHCR is now working on modalities for the repatriation of all these children.

40. While most of the internally displaced persons, victims of the civil war, have returned home to their areas of origin or voluntarily resettled elsewhere, a large number of Sierra Leoneans continue to squat in makeshift houses along major roads in Freetown and in towns in the provinces in subhuman conditions. To address the problems posed by squatting, the Government launched "operation free flow", which involves dismantling makeshift homes and forcefully evicting all squatters. The exercise is still going on; it is needless to say that such measures by the Government need to be complemented by providing real alternatives for those affected.

41. On 24 March 2005, the Governments of Sierra Leone and Liberia signed a memorandum of understanding concerning the repatriation of 397 Liberian ex-combatants who had been interned at the Mapeh and Mafanta Camps in Port Loko and Tonkolili Districts. By the end of April, the voluntary repatriation exercise was completed. However, there still remains a substantial number of Liberian refugees in Sierra Leone, including 13,122 in Kenema District, of whom 6,588 are in Largo Refugee Camp and 6,535 in Tobanda Camp.

G. Economic, social and cultural rights

42. The post-conflict context in Sierra Leone is characterized by massive poverty, high levels of illiteracy (over 80 per cent) and a disturbing high level of youth

unemployment, mostly of ex-combatants. An integrated household survey conducted by the Office of Statistics indicates that 70 per cent of the population lives on less than one dollar a day. Basic services, such as drinking water and electricity, are still lacking in most parts of the country, while health care and educational services are grossly inadequate.

43. Despite improvements in the diamond sector, concerns still remain about health hazards and other patterns of human rights violations in the mining sector. In Koidu, Kono District, for example, kimberlite mining is carried out in locations surrounded by residential areas. The life of the people in the affected communities, including schools, is disrupted when they are forced to evacuate their homes and seek shelter elsewhere during blasting. These environmental impacts and impact on human rights of mining activities should be addressed, especially the plight of those forced to abandon their homes as a result of blasting operations.

III. Human rights activities of the United Nations Mission in Sierra Leone

A. UNAMSIL Human Rights Section

44. The mandate of the UNAMSIL Human Rights Section includes monitoring, investigation and reporting, training and capacity-building, sensitization and advocacy, and technical cooperation. Part of the exit strategy in anticipation of the withdrawal of UNAMSIL is to build national capacity in the area of human rights by involving the people of Sierra Leone in human rights work and encouraging the development of appropriate national institutions. Already, human rights committees have been established in 10 of the 12 districts, including Freetown as the Western area. Through ongoing programmes, it is expected that at least 750 human rights monitors drawn from at least 300 civil society organizations would have been trained in human rights, democracy and the rule of law by December 2005.

45. In the area of technical cooperation, UNAMSIL Human Rights Section is supporting the implementation of the Office of the United Nations High Commissioner for Human Rights (OHCHR) project to support follow-up activities of the Truth and Reconciliation Commission. This includes ensuring the finalization of the report and its distribution, and public awareness activities on its findings and recommendations. In order to ensure continuity of human rights programming, UNAMSIL is also supporting advocacy for the establishment of a National Human Rights Commission, which has been approved by Parliament.

46. In terms of coordination, the Human Rights Section is a full member of the United Nations Country Team (UNCT), and chairs its Committee on Human Rights and its Human Rights theme group. It is also engaged in activities to mainstream human rights in the work of various United Nations agencies. At the district level, Human Rights Field Offices are integrated into and provide human rights capacity to all inter-agency collaborative networks. The Human Rights Section also coordinates closely with other sections of the mission, especially with the gender and child protection officers in the office of the Special Representative of the Secretary-General, the United Nations Civilian Police (CIVPOL) as well as the Public Information Section and the Civil Affairs Section.

47. Additionally, it is also the implementing partner for several projects funded by OHCHR under its comprehensive programme of assistance to Sierra Leone in the area of human rights. Under this programme, OHCHR is supporting the establishment of human rights and law reference libraries, various training activities on monitoring, reporting, follow-up and implementation of recommendations of treaty bodies, as well as the dissemination of the Truth and Reconciliation Commission report and sensitization on its findings and recommendations.

B. Activities in the districts

48. UNAMSIL Human Rights Section maintains offices in 10 of the 12 districts. As part of its exit strategy, it has trained and deployed national staff to work under the supervision of international human rights officers in all its District Offices. All UNAMSIL mandate activities are carried out simultaneously in Freetown and the 12 districts. Local content in the work of the Human Rights Section is also ensured through increased collaboration with local NGOs in monitoring, investigation and reporting on human rights issues.

49. Training and capacity-building activities in the districts continue to be focused on Government officials, especially law enforcement officers, police, military, prison and judicial personnel, and representatives of civil society groups. It routinely utilizes Radio UNAMSIL and other community radios in the districts to expand and reinforce its human rights sensitization and awareness activities.

50. The implementation of the human rights mandate of UNAMSIL entails the establishment and maintenance of an extensive network of collaborative relationships with local and international NGOs, local authorities, schools and teachers. The Human Rights Section participates in the weekly District Security Committee (DISEC) meetings, monthly Child Protection Committee meetings of the Ministry of Social Welfare, Gender and Child Affairs, Police Partnership Board meetings as well as monthly inter-agency coordination meetings of the National Commission for Social Action. It is also engaged with the Transition Support Team of the United Nations Development Programme (UNDP), which serves as an institution of the UNCT to coordinate the decentralization programme of the Government and to support the newly established district councils.

C. Monitoring of courts, prisons and police stations

51. The court system is still generally weak and less efficient than one would have expected after several years of United Nations presence. The major problems are inadequate human and material resources. These have translated into huge case backlogs, excessive adjournments, including of criminal cases, and prolonged pre-trial detentions. The juvenile justice system is virtually non-existent. In the Makeni Prison, for example, UNAMSIL human rights monitors have reported several cases of pre-trial detention for periods ranging from six months to three years. In Kenema, the absence of a judge resulted in the high court not sitting for nearly six months between November 2004 and April 2005. In the same vein, the court in Bombali District did not convene for almost four months.

52. To demonstrate the enormity of the problem, the Chief Justice, in his status report dated 19 May 2005, observed that of the five justices of the Supreme Court,

he is the only substantive member. The other four justices had been reappointed after their retirement on a yearly contract. To address the paucity of judicial officers the Government, with funding from UNDP, justices of the peace were trained and appointed in all of the districts, to assist in the disposition of cases at the magisterial level. However, the Chief Justice has rightly noted, it is untenable to allow the empanelling of justices of the peace to act in lieu of magistrates to be the norm rather than the exception, as it is against the spirit and letter of the laws of Sierra Leone.

53. To address the perennial problem of judges and magistrates, an agreement has been reached between the judiciary and UNDP, providing financial assistance to set up a national judicial institute, which will among other functions train law graduates unable to meet the entry requirements of the Sierra Leone Law School to prepare for the bar examinations. The course, initially to be run by the Sierra Leone Law School, will last for six months and lead to a postgraduate diploma in law. Successful candidates would then be appointed as magistrates. The institute, when fully functional, will also provide training for all judicial officers including judges. In the meantime, consideration is being given to hiring practising barristers as part-time magistrates on a contractual basis to enable the judiciary to clear the backlog of cases.

54. The customary law court system is being gradually improved and consolidated, and a process is now being elaborated to enhance and facilitate the taking of appeal from customary to statutory courts of record.

55. In support of the judicial sector, the United Kingdom Department for International Development (DFID) has allocated £25 million for the reform and improvement of the justice sector. Consultations are taking place under the auspices of a justice sector committee comprising representatives of DFID, UNAMSIL, UNDP and Government addressing issues such as the codification of national laws, codification of the opinions of the Supreme Court, development of customary laws and practices, and training and capacity-building of the police and prisons.

56. Sustained training and capacity-building activities targeting the security forces are bearing fruits, as evidenced by greater professionalism, respect and observance of international human rights standards by the police. So far, over 9,000 officers have been trained by CIVPOL in various aspects of policing, including international human rights standards.

57. One area of notable progress in the operations of the police is family and domestic issues, for which special Family Support Units have been established. So far, these units exist in 21 police divisions and 34 police stations, involving 152 trained personnel country-wide. Through training provided by UNAMSIL, DFID and UNICEF these officials play leading roles in investigating and prosecuting cases of violence against women and children, as well as in raising public awareness of the issues. Despite their success in Freetown and major cities, these units have yet to be effectively created in the districts, and where they do exist, they are grossly under-resourced. A related issue is the question of communal pressure, which sometimes constrains the ability of Family Support Units to prosecute cases.

58. Notwithstanding a general improvement in the functioning of the police, there are still shortcomings in various areas, and mainly as concerns mixing juvenile with adult offenders in detention, irregular involvement of the Ministry of Social Welfare

Gender and Children Affairs or Family Support Units in matters involving juveniles, detention of persons beyond the statutory limit, and transfer of suspects to prisons without duly signed court orders. Efforts are also being made to improve police community relations through the establishment of police partnership boards.

59. A comprehensive study of the prison conditions undertaken by UNAMSIL Human Rights Section in May 2005 shows that prison conditions, although varying at the various facilities, faced five major challenges, namely lack of access to safe drinking water, inadequate health-care facilities and medication, limited facilities for rehabilitation programmes, overcrowdedness, weak supervision and management, and lack of access to legal representation. Efforts should be made to address these shortcomings to ensure that prisons become institutions of reform and rehabilitation, not merely places for punishment.

D. Training and capacity-building

60. As part of its comprehensive programme of assistance to Sierra Leone in the area of Human Rights, OHCHR funds a training programme implemented by UNAMSIL Human Rights. This programme targets local organizations and those affiliated to them. The participation of local groups in human rights committees established in the various districts has facilitated the identification of trainees and follow-up on their progress, as well as mentoring. So far, a total of 305 human rights monitors from 176 organizations have been trained under this project. Training sessions have been conducted in the five major centres (Kenema, Makeni, Koidu, Freetown and Moyamba). It is expected that by the end of the training series, a total of at least 750 human rights monitors from all districts would have benefited from the programme.

61. Training under the project funded by OHCHR has also covered reporting to treaty bodies and follow-up on their recommendations. This aspect of the training responds to the specific capacity needs of Sierra Leone, which although a signatory to various human rights treaties, has been unable to comply with its reporting obligations under the various treaties. In this regard, a treaty reporting training was conducted from 14 to 17 June 2005 in Freetown. Participants in the training were drawn from Parliament and the ministries of Foreign Affairs, Justice, Social Welfare, Gender and Children Affairs, Labour, Education, and Defence, among others. As a follow-up to that training, UNAMSIL Human Rights Section is assisting the Government to draw up a policy paper on treaty body reporting, allocating responsibilities to specific ministries for preparing the reports, and developing a process in which all relevant stakeholders, including the NGO community, can participate.

62. In addition to the comprehensive training programmes for human rights committees, human rights field offices in the various districts also conduct training programmes in specific areas for local groups, and engage in advocacy and sensitization programmes directed at their respective communities. Many of the activities in the districts are undertaken in collaboration with other organizations, some of them international NGOs.

63. To facilitate collaboration and coordination with local groups and various human rights actors, the Human Rights Section provides secretarial support to the monthly meetings of the Freetown-based *Human Rights Committee, composed of*

human rights and pro-democracy organizations in Freetown and Western area. This kind of support is provided in the districts by the human rights officers deployed in the area where the relevant human rights committee is located.

64. The Human Rights Section continues to assist and support the human rights work of international NGOs such as CARE International, Caritas, Global Rights, Defence for Children International, COOPI and the International Rescue Committee through training and capacity-building, and some of these organizations are now also training others in the districts.

E. Technical cooperation and advocacy

65. Within the framework of the comprehensive programme of assistance of OHCHR to Sierra Leone, UNAMSIL Human Rights Section is establishing human rights and law reference libraries in three districts of the country — Bo, Makeni and Kenema — in collaboration with the Sierra Leone Library Board. The Board identified and allocated space for the establishment of the libraries, while OHCHR/UNAMSIL will provide the books, necessary materials and logistics. When fully established, the libraries will be used not only by human rights and pro-democracy NGOs, but also by legal practitioners, students and the general public.

66. Under the same project, human rights books and reference materials will be provided to the Law Courts Library, the Bar, Parliament and key educational institutions in the country, including the Sierra Leone Law School, Njala University College and Milton Margai Technical College. The initiatives in this area have encouraged human rights committees in the rest of the country districts to embark upon constructing their own facilities for training and workshops as well as libraries. The project will be expanded to also provide assistance to these processes.

67. In accordance with the report of the Secretary-General to the Security Council on inter-mission cooperation (S/2005/135), the UNAMSIL Human Rights Section is working collaboratively with the human rights sections of other United Nations missions in West Africa. The head of the UNAMSIL Human Rights Section participated in two inter-mission cooperation meetings for heads of human rights components in United Nations peacekeeping missions in West Africa held in Dakar in March and June 2005. In April 2005, the Human Rights Section received a two person delegation from the Human Rights Section of UNMIL to learn and share the experiences of UNAMSIL in the area of transitional justice mechanisms, with focus on the Truth and Reconciliation Commission. UNAMSIL is slated to host the next quarterly meeting of heads of human rights components in peacekeeping missions in September 2005.

F. National human rights commission

68. In July 2004, Parliament passed a law establishing a national human rights commission. However, the Government is yet to take concrete action towards implementing this legislation. The inability of the Government to take any action in this regard continues to be a matter of serious concern, especially taking into account the human rights challenges facing the country.

IV. Transitional justice

A. Truth and Reconciliation Commission

69. The Government of Sierra Leone released its "White Paper on the Truth and Reconciliation Project" on 28 June 2005. In it the Government expressed its unreserved regrets and sympathy to all those who in one way or the other have been subjected to the outrages occasioned by the war, with particular reference to victims of torture, rape, sexual abuse, sexual slavery, trafficking, enslavement, abductions and amputations, among others, and pledged its commitment to provide remedies. It also accepted most of the recommendations of the Commission, except those requiring the abrogation of the death penalty and the separation of the Office of the Attorney-General from the Ministry of Justice.

70. On the question of reparations, the White Paper merely stated that the Government accepted the recommendations on reparations "in principle", subject to the means available to the State, taking into consideration the resources available to it and assistance received from the international community.

71. As part of OHCHR support to the Truth and Reconciliation Commission process, activities have been designed for implementation by the Human Rights Section to ensure the effective dissemination of the Truth and Reconciliation Commission report and to sensitize the public on its findings and recommendations. In this regard, the Human Rights Section, working collaboratively with human rights committees in the various districts, has facilitated the establishment of dissemination and sensitization committees at district and chiefdom level. To complement this exercise, funds have also been provided under the OHCHR project for the summarizing and translation of the report into local languages, as well as for the printing and distribution of an abridged version of it. To enhance local participation in this exercise, my Office has awarded grants to the Center for Media, Education and Technology (C-MET) and the Truth and Reconciliation Working Group (both of which are local civil society organizations) to participate in the dissemination and sensitization of the report, using the media and other local mechanisms.

72. In order to ensure an effective and sustainable implementation of the recommendations of the Truth and Reconciliation Commission, the law provides for the establishment of a "Follow-up Committee". This Committee is mandated under the Truth and Reconciliation Commission Act to monitor government compliance with and the implementation of the recommendations of the Truth and Reconciliation Commission. The current activities aimed at supporting the objectives of the Truth and Reconciliation Commission would benefit from the establishment of such a committee. In this regard, the Government is urged to take immediate action on this matter, and to speedily implement the recommendations, especially those the Commission characterized as "imperative recommendations."

B. Special Court

73. On 1 July 2005, the Special Court for Sierra Leone entered its fourth year of operation. The second Trial Chamber of the Court is now fully operational; three judges have been appointed to the Chamber and the trial of indictees associated with

the former Armed Forces Revolutionary Council (AFRC) has started. The first Chamber continued the trial of indictees associated with the former Civil Defense Forces (CDF) and the former Revolutionary United Front (RUF), which began on 3 June and 5 July 2004 respectively. In addition to these ongoing trials, the Prosecutor indicated the possibility of additional, albeit limited, indictments linked to existing indictments.

74. Two of the 11 indicted persons, namely Johnny Paul Koroma, former chairman of AFRC and Charles Ghankay Taylor, former President of Liberia, shall have to be brought into the custody of the Court. While Koroma's whereabouts are unknown, Mr. Taylor is in exile in Nigeria, as part of the political settlement of the civil war in Liberia. During my visit to Sierra Leone, I stated publicly that delays in the delivery of Mr. Charles Taylor to the Special Court contributed to a climate of impunity in the region, which could undermine the consolidation of peace in both Sierra Leone and Liberia. Accordingly, I encourage all stakeholders to call upon African leaders to jointly take a position for the surrender of Mr. Taylor to the Special Court in the interest of both justice and peace.

75. On 24 May 2005, the President of the Special Court, Justice Emmanuel Olayinka Ayoola, briefed the Security Council. During the completion phase, the Special Court would wind down its core activities by rendering final judgements against all accused in custody and transferring those who are convicted to appropriate prisons in or outside Sierra Leone to serve their sentences. Already, the Special Court is negotiating agreements with States on the enforcement of sentences, and relocation and protection of witnesses. Based on the current usage of court time, it is estimated that at least one trial will be completed by the end of 2005, and all the trials will be completed at the trial chamber stage around mid-2006. However, there are several factors that could influence the progress of the trial process, ranging from the number of witnesses to illness or sudden unavailability of key individuals participating in the proceedings, to specific factors such as the location in Sierra Leone amidst a fragile and unpredictable political and security climate. Taking into account an estimated time for appeals of between four and six months, the appeals stage could finish by the end of 2006.

V. Conclusions and recommendations

76. **To consolidate peace and prevent a recurrence of the civil war in Sierra Leone, actions must continue in six critical areas, until a culture of respect for human rights has been fully created and entrenched. First, the human rights situation in the country must continue to be closely monitored, investigated, and documented. In this regard, I have recommended, following my mission to West Africa, that the human rights components in UNAMSIL and UNMIL embark on more public reporting on individual responsibilities for human rights violations and other issues of concern in the country.**

77. **Second, training and capacity-building in the area of human rights must continue for relevant institutions of Government, such as the police, prisons and the courts. The civil society in Sierra Leone is still considerably weak and needs concerted training, capacity-building and mentoring.**

78. **Third, the Government must also move quickly to establish a national human rights commission. In the same vein, the Government should promote**

healing and reconciliation, and take measures to disseminate the report of the Truth and Reconciliation Commission, sensitize the people on the findings and recommendations of the Commission, and implement its recommendations. Accordingly, the Government should constitute the "Follow-up Committee" called for by the Truth and Reconciliation Commission Act (2000) to monitor the implementation of the recommendations of the Commission.

79. **Fourth, the justice system must be reformed in order to enhance its capacity to protect and promote the rights of the people, and to serve as an instrument of peace, stability and economic development. In this connection, the Government should spare no efforts in providing resources to ensure that the judiciary performs its roles in an efficient manner and that an effective legal aid programme is established to provide legal assistance to people in rural areas and those who cannot afford to hire a lawyer.**

80. **Fifth, it is imperative to embark on a comprehensive law reform programme to provide the bedrock of respect for human rights and fundamental freedoms. Issues of utmost importance in this regard are the discriminatory practices against women, gender-based violence, in particular the practice of female genital mutilation, domestic violence, rape, child labour, and juvenile justice. This process would be facilitated, should the Government as a priority ratify and implement the relevant international conventions that it has signed, including the Convention on the Elimination of Discrimination against Women, on which extensive consultations had taken place in Parliament. It is also imperative for the Government to implement its treaty reporting obligations and recommendations of United Nations human rights treaty bodies.**

81. **Considering the myriad of human rights issues in Sierra Leone, it is imperative that a strong human rights presence be maintained in Sierra Leone after the termination of UNAMSIL, in an integrated United Nations system as envisaged by the Secretary-General in his twenty-fifth report on UNAMSIL (S/2005/273, para. 63). Through this, much needed support will be provided to the national authorities in the area of human rights.**

82. **The task of combating impunity and promoting the rule of law lies first and foremost with national leaders. I encourage all stakeholders to call upon African leaders to jointly take a position for the surrender of Mr. Taylor to the Special Court, in the interest of both justice and peace.**